BENEFITS, INC
Insurance & Benefit Solutions
www.benefitsolutions.us
P.O. Box 410 Toll Free (877) 461-1424
Decorah, IA 52101 (563) 387-0789
benefits@benefitsolutions.us FAX (563) 387-0682

Flexible Spending Account Claim Form

I. EMPLOYER NAME:_____ **PLAN YEAR ENDING**_____

II. PARTICIPANT NAME: _____**SOCIAL SECURITY NUMBER:** ___ - __ - ____

III. MEDICAL EXPENSE CLAIMS Please attach an Explanation of Benefits from your insurance company; or, if not covered by insurance, attach an itemized bill/ receipt that includes all of the information below. *Canceled checks and bills showing a balance only cannot be accepted as documentation.*

Patient Name	Relation to Employee	Date of Service	Description of Service/Name of Medication	Physician, Provider or Merchant	Is there insurance coverage for this service? If so, an EOB is required.	Amount Incurred	Benefit Code (Office use only)
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		
			TOTAL	MEDICAL CLAIMS	REQUESTED	$	

IV. DEPENDENT CARE EXPENSE CLAIM Please attach the invoice or statement provided by your service provider showing the information below. *Canceled checks and bills showing a balance only cannot be accepted as documentation.*

Name of Dependent	Relation to Employee	Date of Service	Provider of Service	Provider's Social Security Number	Amount Incurred	Benefit Code (Office use only)
			TOTAL DEPENDENT CARE	CLAIMS REQUESTED	$	

VI. STATEMENT OF PARTICIPANT (Read Carefully)

The undersigned participant in the plan certifies that the above expenses were incurred during a period while the undersigned was covered under this FLEXIBLE BENEFIT PLAN and that they, their spouse or dependent has received the service/product described above on the dates indicated. In the case of a Medical Reimbursement Request, the undersigned also certifies that the expenses are for medical care and NOT for cosmetic purposes or for general health purposes and that, if a claim for Over the Counter Medications, the items are used to treat a specific medical condition and you have submitted a letter or prescription from your physician stating the medical necessity. It is also understood that additional information, possibly including a statement from a medical practitioner, may be required to confirm that the expense is to treat a specific medical condition.

The expenses hereby presented for reimbursement from the Plan have not been reimbursed and will not be reimbursed through any other health plan coverage, including other flexible spending arrangements. The undersigned fully understands that he or she is fully responsible for the sufficiency and accuracy of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed as a proper expense under the plan, the undersigned will be liable for the payment of all related taxes including Federal or State income tax on the amounts paid which relate to such expense. The undersigned further understands that no medical or dependent care expense tax deduction or credit is permitted for amounts for which reimbursement is made. The undersigned has read the *Explanation to Participants* on the reverse side of this form.

_____ (___) _____ _____
Participant's Signature Daytime Phone # Date

email address _____